MONITORING REPORT

Program Support Bureau

Quality Assurance Division

County of Los Angeles – Department of Mental Health

Provider Name: _____ Date: _____

Program Manager's Name: _____ Provider Number: _____

1. **Select Type of Quality Assurance Process**:
   - ☐ Formal QAC (agenda, minutes, set membership, meeting time, formalized procedures
   - ☐ Other QA Process (Individual / Team / Inherent Case Flow)
   - ☐ QAC pending (Reason: _____)
   - ☐ QAC suspended (Reason: _____)
   - ☐ No QA Process (Reason: _____)
2. If you have a QAC / QA Process, how <u>often</u> do you meet? ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other _____
3. Did your QAC <u>void</u> any claim(s) during this quarter? ☐ NO **OR** ☐ YES (If YES, how many? _____)

INSTRUCTIONS FOR SUBMISSION OF QAC / QA PROCESS MATERIALS

1. On a quarterly basis, please submit forms and materials from <u>one (1) QAC meeting per quarter</u> to DMH – Program Support Bureau QA Division.
2. The submission <u>deadline</u> is on the 15th of the following month of the quarter. Please select your month of submission:
   - ☐ <u>First</u> Quarter (Jan/Feb/Mar): April 15th
   - ☐ <u>Second</u> Quarter (Apr/May/June): July 15th
   - ☐ <u>Third</u> Quarter (July/Aug/Sept): October 15th
   - ☐ <u>Fourth</u> Quarter (Oct/Nov/Dec): January 15th
3. Please <u>fax</u> the following materials to DMH QA Division at FAX# (213) 381-8386 (please adhere to the HIPAA Compliance faxing procedure):
   a. Sign-in sheet
   b. QAC Agenda
   c. Minutes of the QAC Meeting
   d. Client initials and IS numbers of 5 cases reviewed
   e. A completed QAC Chart Review Tool for each of the 5 cases reviewed.
   f. Completed QA Data Time Form

TO BE COMPLETED BY QUALITY ASSURANCE DIVISION STAFF ONLY

Received By: _____ Date: _____ QA Team Review Date: _____ Selected For On-Site Review: □ YES □ NO

QA Lead (s) Printed Name: _____

Printed Name: _____

DRAFT